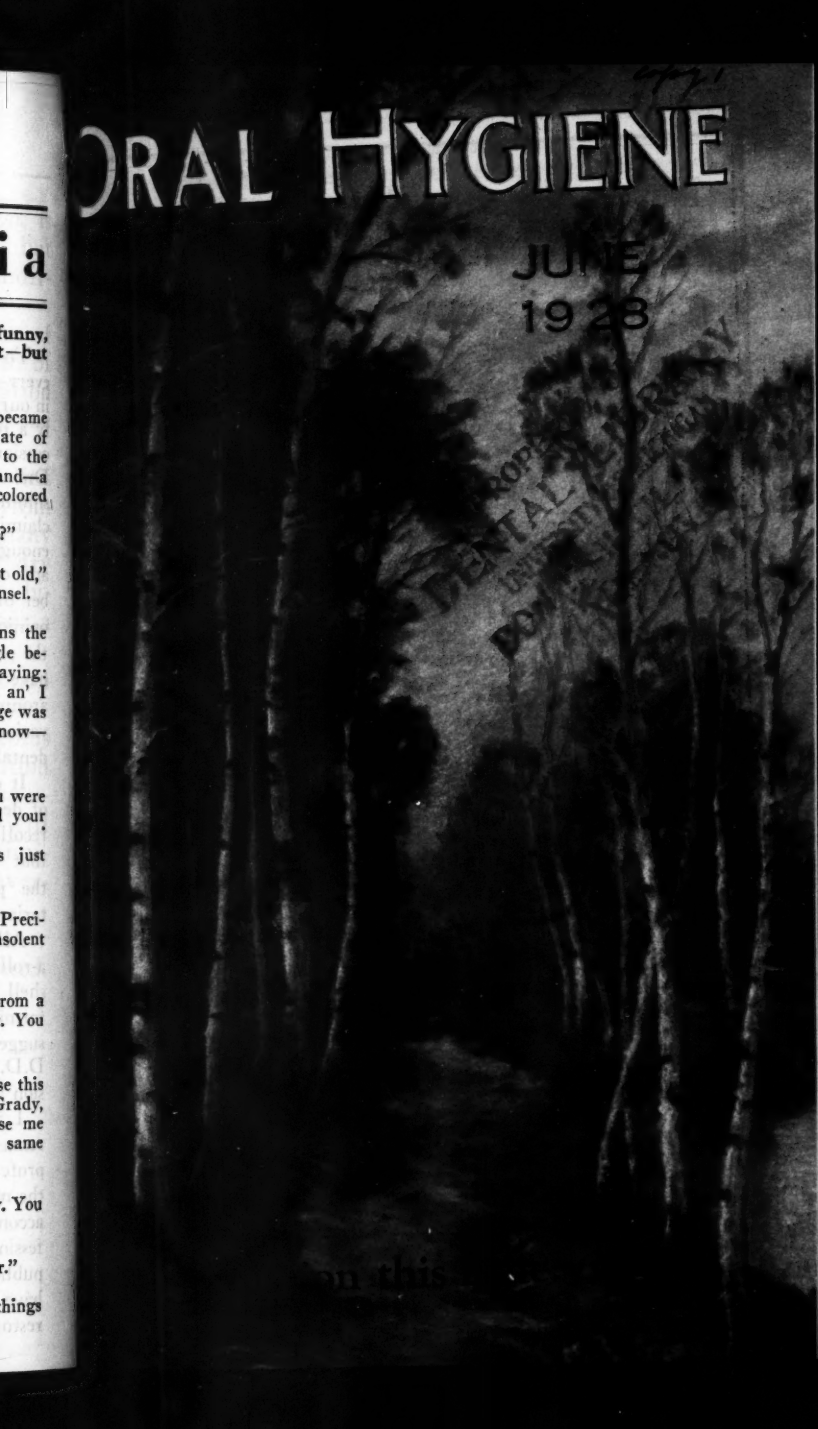
ORAL HYGIENE
JUNE
1928

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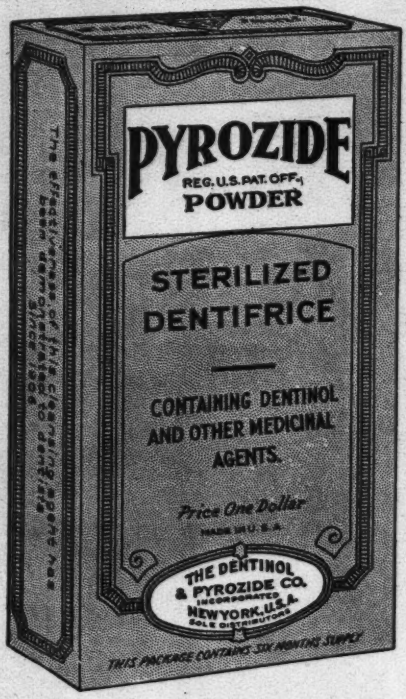

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Sterilized—Medicated Dentifrice

Prescribe this dentifrice for reducing gum irritation.

It keeps the gums hard and firm.

It is effective in removing deposits.

As a cooperative medium your patients will note its superior qualities in keeping the teeth and mouth clean and the gums hard.

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CONTENTS

June 1928

Practice

General

ORAL HYGIENE

Registered in U.S. Patent Office—Registered Trade Mark, Great Britain

A JOURNAL FOR DENTISTS

EIGHTEENTH YEAR | JUNE 1928 | VOL. 18, No. 6

Eddie Kells

—

October 21, 1856
May 7, 1928

The Dentist

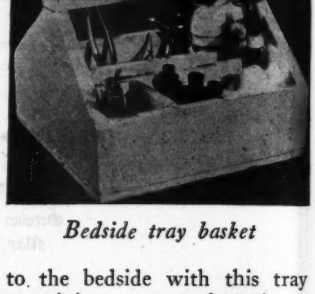
By William Ersner, D.D.S., Philadelphia,
Assistant Visiting Oral Surgeon and Chief
Dental Clinic, Philadelphia General Hospit

WHEREAS the dental service is a distinct department in the hospital like all the other services, we find that we are responsible for the oral hygiene and dental care of every patient. In an institution such as the Philadelphia General Hospital, where in 1926 we had an average daily census of 1,577 patients, we can just about scratch the surface in the care of the patients dentally, for to do so correctly would require a very large staff of resident dentists.

One soon realizes the magnitude and responsibility of the service. With three graduate dental interns, we were averaging about 40 patients daily and approximately 800 treatments per month, in the dental clinic, operating clinic and at the bedside. It is the bedside patient with whom we are mostly concerned, for we find that approximately 65 per cent of our work is required at the bedside.

BEDSIDE TRAY BASKET

In order to do this work at the bedside properly and not in a slipshod manner, it was necessary to devise a plan of service which has succeeded admirably. For convenience we constructed a bedside tray basket. We went



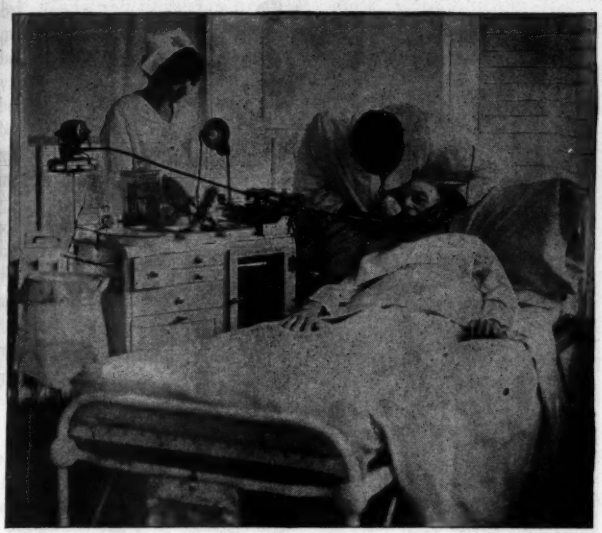
Bedside tray basket

to the bedside with this tray containing a mouth mirror, cotton pliers, standard extraction forceps, hypodermic syringe, bottle of novocain, adrenalin, iodine, mercurochrome and a pocket flash light. At best the examination of the patient under these conditions was superficial and the tray provided only for the treatment of two patients, for we soon exhausted our supply of sterile instruments. This condition made it necessary to return to the clinic for a new stock of instruments, which caused a great loss of time in the routine work of the dental surgeon.

EARLY DENTAL CONSULTATION AND CARE WILL REDUCE HOSPITALIZATION

Dentistry is a branch of medicine. We, in our respective

e Bedside*



The bedside unit in action

field play just as important a role in the maintenance and bringing back to health of the patient as the oto-laryngologist, the ophthalmologist or any of the other specialists. We must realize that dentistry has passed the stage of mechanics. While the mechanical side is of great importance for the replacement of the masticating apparatus, the all-important findings of the many clinicians is that therapeutic measures instituted towards the elimination of the otal infections have resulted in definite improvements and started the patient on the road to health.

Dental consultation for practically all patients is our aim. However, not all patients can come to the clinic for our service, so that with a great many we had to wait for a long time before the patient was somewhat improved and could be brought to the dental clinic. Yet, it was this dental service which in a great many cases was of the utmost importance. In many instances the dental defects were the causative factors or the foci of the particular ailment.

We realized that if we could take our dental service to the

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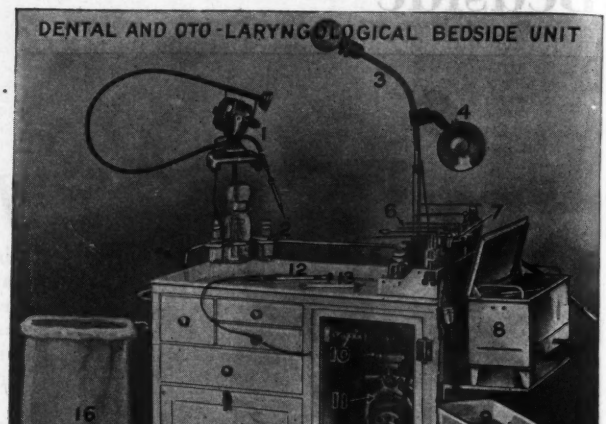


1. Dental engine.
2. Container for syringe and local anesthesia solutions.
3. Nose and throat light with condenser.
4. Projection light for operating condenser.
5. Medicine bottles.
6. Spray bottles.
7. Air pressure for sprays.
8. Sterilizer.
9. Swinging instrument tray.
10. Diagnostic lamp rheostat.
11. Pressure and suction pump.
12. Mouth lamp and mirror.
13. Trans-illumination.
14. Head lamp.
15. Dressing jars.
16. Soiled towel bag.
17. Foot control for dental engine.
18. Negative pressure for aspiration.

bedside, make a thorough examination with recommendations and if deemed advisable by the visiting physician or surgeon, render our service at the bedside, it might hasten the convalescence. This would not only be a valuable item economically, but we would be an aid in creating more room for the waiting patient.

The dental unit lends itself so readily for other special bedside work that the apparatus described here was devised to answer the purpose both of the dental surgeon and the oto-laryngologist.

DENTAL-OTO-LARYNGOLOGICAL BEDSIDE UNIT

After constant use over a period of three years, we found this unit lends itself admirably in the following ways:

1. By wheeling this unit into the ward, we have practically a mobile dental office at the bedside.

2. A complete nose and throat outfit for the bedside.

3. A compact and complete nose and throat outfit for the small office.

In presenting this unit, I wish to call attention to the fact that it is a combination of components on the market, is flexible and one can add any or all the parts to this unit as required.

AS AN AID TO PRE-OPERATIVE PATIENTS

All patients about to be operated upon should have proper oral hygiene, for all surgeons and anesthetists believe it will lessen the danger of aspirations of tartar, loose debris, snags and loose teeth during anesthesia. The ambulatory patient can be brought to the dental clinic, but here again the bedside unit is of great value for we can render the oral hygiene service at the bedside with very little inconvenience to the patient.

ORAL EXAMINATION AND DIAGNOSIS

Dr. Joseph C. Doane, our Medical Director, said: "The history chart of a patient is as valuable as its finest details." Proper oral examination is very important at all times. The dentist is the one responsible for this phase, as he has been specially trained to do this type of work, the medical intern having no training in oral diagnosis.

The dentist is a spoke in the wheel of health. He must rule out all pathologic conditions for the proper care of the patient. The time has passed when the dentist sees only the mechanical defects. He must be alert and by a systematic examination note all mechanical defects, pathology not only of the teeth, but gums, buccal mucosa, tongue, palate and floor of the mouth. The dentist should be the first to discover all precancerous conditions in and about the mouth. To make this examination, I have suggested the accompanying chart. It is of an individual color (gray). This makes is easy to refer to. It is simply constructed so the medi-

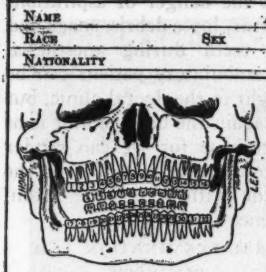
PHILADELPHIA GENERAL HOSPITAL—Department of Oral Surgery

DENTAL AND ORAL-SURGICAL RECORD

NAME ADDRESS DATE

RACE SEX AGE WARD DIAGNOSIS

NATIONALITY OCCUPATION



CHIEF COMPLAINT

PAST HISTORY AND PRESENT ILLNESS

ORAL EXAMINATION

LIPS

GUMS

TEETH

CHEEKS

MANDIBLE

TONGUE

SUBLINGUAL REGION

SUBMAXILLARY REGION

MAXILLAE

PALATE HARD

PALATE SOFT

MAXILLARY SINUS TEMP. MANDIBULAR JOINT

RECOMMENDED FOR X—RAY

X—RAY NUMBER FINDINGS

TENTATIVE DIAGNOSIS

RECOMMENDATIONS

EXAMINED BY CHIEF

DATE	PROGRESSIVE TREATMENT	OPERATOR

Record filled out when patient is examined

cal intern and medical chiefs have no difficulty in understanding our findings. The Periodic Health Examination Committee of the Philadelphia County Medical Society requested the author to draw up a dental chart. The above chart, with a few changes, is now in use by the Philadelphia County Medical Society.

When a patient comes to the dental clinic we can make a proper dental and oral examination, but to do so at the bedside was difficult. With the use of

the conveniences offered through the dental-oto-laryngological bedside unit, bedside examination was simplified and can be done correctly.

X-RAY OF TEETH AND DIAGNOSIS

Under our service we are responsible for the dental x-ray. We have a completely equipped dental x-ray room. It is located in the x-ray department, under the direct supervision of Dr. E. Burvill-Holmes, director of the x-ray department. Before taking the x-rays of the teeth the dental intern examines the mouth clinically. This gives us the opportunity to give a clinical, as well as roentgenographic diagnosis, as one without the other is valueless.

ORAL HYGIENE AND PROPHYLAXIS AT BEDSIDE

We all know the value of the clean mouth at all times. However, the value of a clean mouth increases a thousand-fold in the case of a patient. If the patient can come to the dental clinic for prophylaxis and treatment, that simplifies matters. If the patient is non-ambulatory, he deserves the same consideration. Of course, prophylaxis at bedside is more difficult than at the dental chair. With the aid of the bedside unit, conditions are helped.

For some time the oral hygienists from the University of Pennsylvania Dental School were doing bedside prophylaxis under our supervision. They made use of the bedside unit to great advantage and their work was accomplished equally as well as at the chair. At the present time we have a full-time hygienist, who does our prophylactic work at the bedside on the selected cases. Along with our efforts we carry on an active campaign among the patients to keep their mouths clean and to use the tooth brush. The hygienist spends a great deal of her time among the child patients. It is with them that the greatest good can be accomplished.

EXTRACTION OF TEETH AT BEDSIDE

Of course, extensive removal or difficult extraction of teeth is never undertaken at bedside. It is always most advisable to do that type of work either in the dental clinic or in the main surgical clinics. We limit the extraction of teeth at bedside to those requiring local anesthesia. However, the simple extraction of teeth at bedside requires a great deal of care and special training. There is a great difference in technique in the removal of teeth at the dental chair and at bedside. Likewise, there is a great difference between the practice of office dentistry and hospital and bedside dentistry.

It is to gain this experience that the far-sighted young men who graduate from the dental schools take to a dental internship. It is my personal opinion that the time is not in the far future when the dental schools will establish in their curricula, departments which will teach men the value of hospital training, hospital dentistry, correct

oral diagnosis in its relation to systemic diseases, the real and relative meaning and interpretation of the medical and laboratory history and findings.

DENTAL PROPHYLAXIS WILL REDUCE HOSPITALIZATION

When we stop to consider the findings of such men as Rosenow, Billings, Hartzell, Mayo, Hayden and a great many other investigators, we must recognize the very great importance of the theory of focal infection, and the very close and important relationship between diseased teeth, gums, and other oral pathology to the general systemic disturbances.

Bacteria from pathologic areas in and about the teeth have been injected into animals, and also similar organisms recovered from infections set up by them.

The most prominent research work along these lines was the theory, proven time and again, known as elective localization. Organisms taken from cases of acute infection and injected into animals have produced the same lesions and diseases in the corresponding organs in the animal as those from which the bacteria were taken.

THE RELATION OF TEETH TO TONSILS, NOSE, THROAT AND EAR

Many cases of tonsillitis are caused by the presence of badly infected teeth and the presence of pyorrhea pockets, snags, and by the unhygienic mouth. If the laryngologist will consider dental origin for many of his recurrent abscesses or quinsy throats, he will do so wisely. Many such cases have come under observation. Especially is this true of the ever troublesome impacted lower third molar or wisdom tooth. Likewise this condition may be brought about by the infection about the gum flap over the wisdom draining into the lymphatics involving the tonsils and glands in the floor of the mouth.

MAXILLARY EMPYEMAS

The infected tooth in the upper jaw should always be considered in connection with maxillary sinusitis. Their close anatomical relation makes the teeth a vital factor. In view of this we have made it a practice to remove all teeth which are devitalized and in close proximity to the antra, whether they are roentgenographically positive or negative, and most certainly all teeth showing involvement at root ends and also teeth with pyorrhea pockets.

REFLEX PAIN, NEURALGIA AND HEADACHE

Patients suffering with reflex neuralgia and pain should have close scrutiny of all teeth. Careful examination should reveal all cavities. Every tooth should be tested for vitality. We must not overlook pulp stones, exostosed or pericementosed roots, retained roots, infected teeth, and especially impacted teeth. We must learn to expect impactions of any tooth in the mouth, although the most preva-

lent are mandibular third molars, upper third molars, cuspids upper and lower, as well as any of the other teeth.

REFLEX OTALGIAS

The pathological conditions found in and about the mouth are a great source of the reflex otalgias, otitis medias and occasionally troublesome in the acute mastoiditis. Many phases of impairment of hearing, tinnitus, have been eradicated by the removal of the dental foci.

TEETH IN RELATION TO EYE INFECTION

It is generally conceded that next to syphilis the most common cause of inflammatory ocular infections is focal infections.

Prominent among the ocular infections are conjunctivitis, iritis, retinitis, keratitis, optic neuritis, scleritis, choroiditis and glaucoma, and the other eye ailments which will attract our attention. Especially is this true if an ocular affection is cleared up as if by magic upon the removal of a few infected teeth. Of course, tonsils and sinuses are to be considered.

Ofttimes a combination of sources of foci may be the causative factor and all must be removed.

Reflex ocular disturbances are frequently caused by irritation of the dental branches of the trigeminal nerve. The exciting causes, such as impactions, obscure caries, sensitive conditions of the necks of teeth with dying pulps and all conditions which can be eradicated early for the patient presenting ocular disturbances. If there is any condition in which we should be radical and institute immediate operative procedure in the removal of teeth as a foci, it is in the ocular conditions, for we all know the seriousness of the loss of an eye.

Not all cases of stomatitis are to be considered as pyorrhea or gingivitis. We must be sure to rule out the very prevalent condition found so often in unhygienic mouths, which is the rule of the majority of hospital cases. It is to be remembered that the Vincent's spirilla and fusiform bacillus may be found in the normal mouth. Lowered vitality predisposes the patient and before we are aware, the Vincent's infection, ulcerative stomatitis, or trench mouth as it is commonly known, becomes active. This condition must not be overlooked and should receive active attention. When the lesions are present in and about the teeth, gums, buccal mucosa, floor of mouth, tongue and lips, it is known as Vincent's infection. When the lesions are present on the tonsils and pharynx it is then known as Vincent's angina. Here co-operation is required of the laryngologist and the dental staff, both treating to eliminate this disease according to their respective fields. This condition is serious if not treated and taken care of, and is often associated with other diseases and becomes a very serious handicap for the recovery of pa-

tient's ailment. Hygienic restoration of mouth in these conditions should be restored as soon as possible by the dental staff. This condition may be the cause of very serious sequelæ and surely predisposes patients to pulmonary ailments.

The unhygienic mouth, snags, roots and infected teeth are of great import to patients afflicted with pulmonary ailments. Aspiration of bacteria from Vincent's, bacteria in carious teeth, etc., should be considered. We take care of the tubercular patients in special dental clinics in both the men's and women's tuberculosis buildings. Hygiene is stressed, patients given tooth brushes, and we make an effort to conserve the dental arch, and extract all teeth which we believe may, at some future time, become troublesome and infected. Removal of infected teeth for the tubercular patient is oft of serious consequence and may presage a tubercular necrosis.

DENTAL PROPHYLAXIS AND DENTAL CARE FOR METABOLIC PATIENTS

Of great importance is the care of patients with metabolic disturbances. Especially true is this of patients with diabetes. Blood sugar may remain high on account of some dental infection. Just as soon as diabetes is diagnosed, dental prophylaxis should begin. Care should be taken not to cause any undue injury to the gums. All devitalized or infected teeth should be removed, as well as all teeth that are doubtful. The removal of infected teeth has made possible the reduction of the blood-sugar and, therefore, made possible the reduction of insulin in the treatment of diabetes.

DENTAL PROPHYLAXIS IN ANEMIA

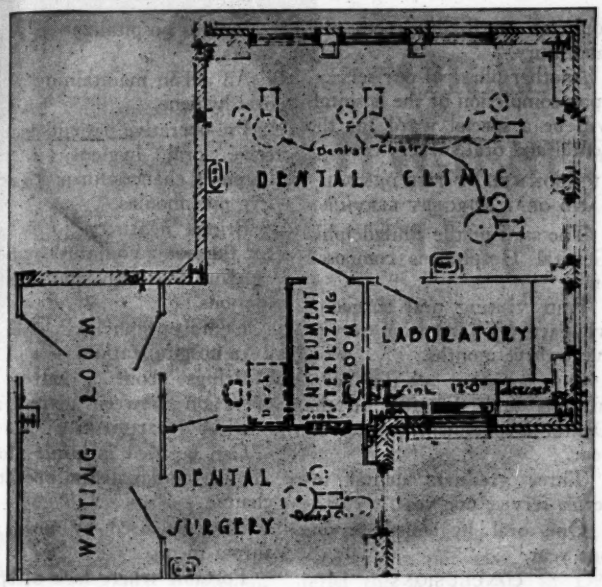
Focal infection should be eliminated in all anemias, and dental prophylaxis is also a great factor in these conditions.

DENTAL PROPHYLAXIS IN OTHER DISEASES

Dental prophylaxis is a great factor when intelligently pursued and eliminated in the arthritis deformans, various heart diseases—endocarditis, myocarditis, pericarditis, kidney diseases, gall bladder and liver diseases—cholangeitis, cholecystitis, hepatitis, abscess of liver, intestinal diseases—enteritis, ulcer, colitis, appendicitis, ulcer of stomach, sciatica, neuritis and many other diseases.

In general, we find ourselves responsible for the prophylaxis and dental care of all patients, irrespective of ailment.

Therefore, is it not reasonable to assume that if dental prophylaxis is indicated in all diseases, we should apply our treatment early in order to help the patient recuperate sooner? If the patient is treated therapeutically only, he often gets well, but the disease will return if foci have not been removed. Early care, therefore, also prevents return of patient to hospital with the same disease. *We*



Floor plan of the clinic

believe that dental prophylaxis reduces hospitalization.

PRESENT DENTAL CLINIC

Our clinic has four complete equipments. We also have a laboratory for the mechanical work. In addition to the above we have two dental clinics with complete equipments located in the women's and men's tuberculosis buildings.

THE FUTURE OF THE DENTAL SERVICE

The future of the dental service at the Philadelphia General Hospital reads like a dream. It will soon be an actuality. The dental service has been in existence at this hospital for almost thirty years, long before the theory of focal infection.

The new dental clinic is located on the second floor of the administration building. This is located in the center of the entire new hospital, making it easy of access from all over the institution. We will have a waiting room, operating room for our minor operations and gas anesthesia, and the major surgery, as before, is to be taken care of in the main surgical clinics. There will also be a modernly equipped dental clinic with four complete outfits for our operative and prosthetic dentistry and a completely

equipped sterilizing room and laboratory.

Another phase of our service, upon completion of the hospital, will be a special ward for the dental and oral surgery cases.

PERSONNEL OF THE DENTAL AND ORAL SURGERY SERVICE

The staff of the Philadelphia General Hospital is composed of:

Four visiting oral surgeons, who are on a rotation service every three months.

One assistant visiting oral surgeon and director of the Dental Department, service all year.

Three graduate dental interns, service one year.

One oral hygienist, service one year.

CONCLUSIONS

A factor in economical hospital administration.

Lessens hospitalization of patients.

An aid in maintaining better oral hygiene.

Pre-operative patients can receive oral hygiene, thereby lessening chances for post-operative pneumonias.

Brings dentistry to bedside for the non-ambulatory patient.

More thorough mouth examinations.

Dental prophylaxis will reduce hospitalization.

Brings about a better cooperation between dental and medical departments.

Can be used in clinic alongside of regular dental operating chairs.

May be used by nose and throat men.

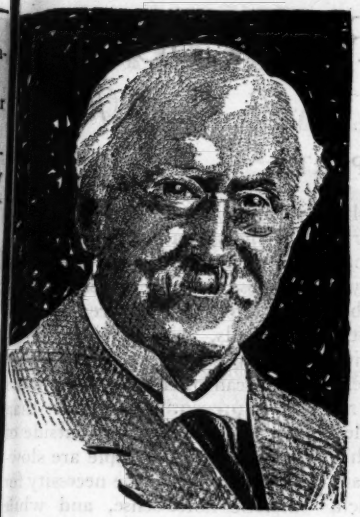
Portable where lack of space in hospital prevents complete outfitting of a dental clinic.

This month's cover is from the original painting by William Thompson, entitled "Memory Lane."

Quiet, serene and restful, here is a scene that lures the imagination with its poetic beauty and delicate charm. Calm appraisal soon fades into dreams and awakening memories.

It is by his sympathetic faculty of portraying scenes of such endearing quality that Mr. Thompson has won his place among the popular artists of today.

In composition, the picture is unusually fine and there is true beauty in the lane of slender birches bordering the path. The artist has nicety of expression and shows a rare color sense in the soft blends that still retain richness and depth.



ORAL HYGIENE'S Old-Timers Series

RECENTLY Dr. Beebee of Rochester, New York, was tendered a testimonial dinner by the members of the Seventh District Dental Society of the State of New York at the Rochester Club.

Dr. Beebee retires after 43 years of active practice in Rochester.

He was born in Hamilton, N. Y., on October 7th, 1852, being the son of Professor Alexander M. Beebee who, for 40 years, was dean of the Theological Seminary at Colgate University. Dr. Beebee attended Colgate and was graduated with the class of 1874. He then took two years of post-graduate work and received an A.M. degree in 1876.

After leaving college, Dr. Beebee studied medicine for two years but gave up the idea of becoming a physician, and entered the dental office of Dr. A. M. Holmes in Morrisville, N. Y. After concluding a student's course in Dr. Holmes' office, he began the practice of dentistry in DeRuyter, N. Y., in 1877. Later he practiced in Brockport, and went to Rochester in 1885.

For more than thirty years Dr. Beebee maintained an office in the Commerce Building where he was associated for a number of years with the late Dr. Walter.

He is a past president of the Rochester Dental Society and the Seventh District of the Dental Society of the State of New York. The committee in charge of the testimonial dinner was headed by his close friend, Dr. G. C. Lowe.

PROFESSIONAL

By Frank W. Cha[illegible], L. L.,

PART I

DENTISTRY is a public need. It is not a luxury, inasmuch as anything that has to do with health and physical betterment of the people becomes a necessity. As a necessity, dentistry embodies preventive and curative measures, and dentistry from a standpoint of replacements should be handled not as the exclusive luxury that it is today, but should be available to the poor and the rich, the old and the young, irrespective of creed, color or class. The service should be compulsory in the young, and only by such means can the known blessings of dentistry become universal in its preventive, curative and restorative phases.

Pain knows neither time, position nor nationality, and any service that does not alleviate pain to all the people all the time is self-limiting in its universal good. I am not a socialist, but I question the right of a government to deprive its citizens of the fundamentals of health by placing without the reach of all the people the dentistry upon which the nation lowers or raises its physical well-being.

Individual welfare means community welfare, and community welfare means national welfare, and failure to provide to any part or class of people the right to a healthy body and the pleasure of living is not the purpose of government. I am not offering a panacea for human ills, but dentistry as a known science, correctly handled, can offer the people more as a preventive measure than any one advancement outside of sanitation. The people are slowly awakening to the necessity for dietetic horse-sense, and while dietetics have a great deal to do with the maintenance of the body, still environmental conditions do and always will be a determining factor, even under strict conditions of hygiene and dietetics.

Dentistry is known and appreciated only in proportion as the contacts with the dental profession have been satisfactory, and the advice and work of the dentist constructive. Certain localities throughout the United States are known as good dental centers, but they merely reflect the professional integrity and constructive work of the members of the profession, covering a long period of time. There are other centers where it is said that fees are low and that dentistry is not appreciated. In the last analysis that is merely a reflection of the weakness of the members of the

ONTANDARDS

. Cha J. S., Hollywood, California

Drawn for
ORAL HYGIENE
by Lewis Hymers

dental profession who throughout the years have made the public estimate of dentistry in such localities just what it is.

Whatever the public knows of dentistry has been taught them by the members of the dental profession, and if the representatives of the profession have not done their work according to the highest teachings of dentistry, and their social contacts have not been in keeping with high standards of citizenship,

then dentistry can not be very highly esteemed in that community.

A dentist must not be exclusively a mechanic. He is principally an educator, and if he has not fulfilled his mission, then the entire profession must suffer, at the expense of those whose activities are not circumscribed and not limited to their own selfish ends. A professional man should have a willingness to serve and compensation must and always will be in proportion to the service rendered, and that service must primarily be predicated upon knowledge, honesty and a sincere willingness to give more than is contained in the oral contract or more than is measured by the dollar standard.

Brains create desire, and although we cannot legislate brains into a man's head, morals into his soul nor sympathy into his heart, a man with the handicap of small brains can still by education have a willingness to serve, and the man with the biggest brain who has not that willingness to serve is a detriment to the good intentions and works of those of less technical or intellectual capacity.

There is no high or royal road to success, and irrespective of personality or any applied psychology courses or any so-called rule of practice, nothing can make a man a success unless he has a thorough knowledge of the subject. The world pays all for initiative. A man is primarily paid for initiative, and if that initiative is backed by fairness, by knowledge, by honesty and a willingness to serve, nothing can stop that individual from being a success. There are a few individuals who give sufficiently to be even entitled to success, particularly in a life of service such as the dental profession, where self should be submerged for the definite ends of our purpose.

Personality reflects heredity, and personality can be capitalized almost without exception, both for an increased service and personal satisfaction, or it can be restricted to selfish accomplishments, which in the end do not bring happiness. Nothing adds so little to cheerfulness as riches, and nothing so much as good health, and the happiness that a man obtains in this world is that which he has within himself. Wealth does little for our happiness, and in the end all the advantages pass and character alone remains. Those of our profession from a psychological standpoint, work within the so-called four walls. Their contacts are many, but not from the vantage point of one who competes openly, as the attorney, whose weaknesses are capitalized by his opponents. The world shapes itself to our personal viewpoint, and sometimes we become biased and narrow, oftentimes laggards in the field, due to lack of external stimulation, and the stimulation of different contacts that, after all,

add zest to life. There is no other advantage equal, from a personal standpoint, to a great mind or a great heart, and money is not a worthy substitute. The happiness that we receive from ourselves is greater than that emanating from our surroundings, and that happiness only comes from the accomplishment of our ideals, and a professional man's ideals cannot be greater than a hope for greater service to the public, as a professional mand and as a citizen.

The chief weakness on the part of many dentists is the selling of articles. They delight in trinkets, and dentistry, outside of the elimination of pathologic conditions and the teaching of prevention, is today primarily tinkering and patch-working. There is nothing permanent in the average piece of dentistry. I could not imagine a physician charging so much per gallstone, but rather he places a valuation upon the services rendered, his ability to render that service, and the benefit to be derived by the patient.

The average net earning of a dentist in the United States is less than the average net earning of a skilled mechanic, who has not the mental training or education, nor educational or equipment investment or responsibility, which goes hand in hand with professional ministration. The fees throughout the United States are on an average low, with exceptions here and there where they are high, and the deduction follows that it takes very much to be an able man, to be a real success. He must be many-sided, with many accomplishments in this world of activity, where the end result is supposed to spell success.

It seems to me that many men fail from selfishness and a lack of the prime essentials of courtesy, all classified as a bad introduction. One of the outstanding salesmen in the dental supply business told me some years since that if you wanted a true estimate of a professional man, you should call upon him in his office. A small man would invariably be too busy, and by being so busy endeavor to impress the caller with his marvelous practice, and the busy man would be the one who had a minute to see virtually all comers. It seems to me that the real estimate of a man is his ability and his willingness to give of himself to increase his contacts, which after all are the source of individual success.

It is a rare man indeed who can treat his brother in business as he would like to be treated. It is a hard thing for a dentist to keep from knocking his fellow practitioner, from eternally crowing about the superiority of his own ability and always deprecating the work of another man, being both judge and jury, and in fact paint himself white and the other man black with the same brush. This is one of

the great reasons why the public has so little confidence in the opinion of the average dentist.

It is safe to assume that a patient going to five dentists with a given set of x-rays, would have five individual opinions, and the patient would become bewildered as to whom to believe. This proves conclusively that dentistry neither in practice nor in theory is standardized, and that the essentials in treatment are as variable as the weather. Some one out of the five men very likely expressed the truth and was theoretically and scientifically correct, and if one of the five men was correct, what is the matter with the other four?

It has been said that the average dentist is merely a retailer of dental materials. That is not original with me, although I may support it in part. If the contentions I have advanced are true, what is the solution of this problem that when settled will allow us to take our place as members of a true profession, whose work is not only restorative, but preventive and curative as well?

I question the present curriculum in our universities as being sufficiently standardized to allow men to acquire sufficient knowledge in the field of pathology and in the field of therapeutics and from a diagnostic standpoint to dispense conclusive statements according to the present-day demands upon the dental profession. We have long been subservient and inferior to the medical profession in the so-called fundamentals, without which we are not in a position to diagnose diseases which, local from our standpoint, may be systemic in origin, and on the other hand local manifestations may give rise to a general systemic disturbance that we are not able to combat and seldom to diagnose. I am in favor, then, of a course sufficiently comprehensive to place a dentist upon a par with a medical man, and which will then make dentistry a branch of medicine and the dental profession a specialty of medicine rather than separate and distinct and with a handicap to render the service demands made upon us.

(To be concluded in the July issue.)

Old Style Turnkey for Museum

Dr. S. B. Crozier of Belmont, Ohio, has an old style Turnkey, dated 1782, which he would like to place with a museum or historical society interested in securing this rare specimen.

Kayoing the Interproximal Radiographic Examination

By C. Edmund Kells, D.D.S.,
New Orleans, La.

GOSH! Can you beat this? In the August number of *Hettinger's News* Dr. Weber starts some trouble with a little article the caption of which is: "Is Dr. Kells Always Right?"

Mr. Editor, if you are offering any prize for the most foolish question that anybody in the world could possibly ask, please call up Dr. Weber and make the presentation. Why are folks always "picking on" poor me anyway? I never do 'em anything.

Now Dr. Weber, you have asked a plain question and I hope I get in my answer before anybody else beats me to it.

Am I always right? *Decidedly not!* The probabilities are that, "dodo" that I have been called, I am oftener wrong than right—that is, according to modern teachings.

According to these modern teachings, I am altogether wrong about the interproximal radiographic examination—yes, altogether *wrong* and I cheerfully admit that I am wrong, but *I don't believe it all the same,* and now I'll tell you why.

The most ardent advocates, themselves, of this method sure do give their little hobby the worst kind of a black eye. The more they write about the examination, and the more they illustrate it, the worse it is for them. If you don't believe that, then "listen in" on this:

In one of the very latest editions of a leading text-book is shown an example of this kind of an examination. Two upper centrals each had two large typical crescent shaped proximal cavities. About one-third of both the labial and lingual walls, both mesially and distally, of the centrals were gone.

Just imagine it! Four great big cavities in the centrals, so big that I reckon the teeth would have to be crowned, and their skiagraphs shown to prove the value of the ray in such interproximal examinations. That is where I say the author kayoed the examination.

A photograph would show these cavities to advantage. A blind man could readily *see them with his fingers,* and yet the teeth were *rayed in order to show the advantage of this kind of an examination;* and their illustration is found in a text-book. Come now, "cross your heart and hope to die"—isn't

that a perfectly absurd illustration? Will such an illustration convince you, "kind reader," of the value of such an examination?

If the ardent advocates of this kind of an examination would confine their illustrations of its value to cavities that cannot be seen by the naked eye, it would be one thing, but when they show teeth with cavities that are perfectly visible at a glance, why that is what knocks the whole business cold, as far as I'm concerned.

I would ask you to turn to Brother Raper's *Clinical Preventive Dentistry,* pages eight and nine, and examine certain of his own illustrations which he presents in order to impress us with *the value* of the ray for this purpose, and then place *your own value* upon most of these films.

Then again, turn to page twenty-three. Here arrows numbers one (upper row) and three (lower row) point to cavities upon the proximal surfaces of anterior teeth, which teeth are shown by their shadows, not to be in contact!

Come now, be honest—if a dentist needs to skiagraph such teeth *which are not in contact* (cavities in anterior teeth and staring at him) for the purpose of finding cavities upon *surfaces that are visible,* don't you think that he has mistaken his calling?

Dr. Weber, won't you admit that it is practically impossible for a patient to present with one or more cavities in the lower incisors that cannot be most readily discovered, and yet these men advocate the raying of such teeth right along as routine procedure. Come now, Dr. Weber, would *you be willing to pay* for such a film of your own teeth? I doubt it.

Another question, Dr. Weber: Referring to your patient who has "thirty-two of the finest teeth that it has been my good fortune to care for"—tell me, did you ray his lower incisors which were among the finest teeth that you ever saw, and if yes, did you *charge for the film?*

Now, my dear Doctor, you say that in this splendid set of teeth (of which the left upper second molar was a sample), the film disclosed a cavity upon the mesial surface of the left upper second molar, which was so large that it almost involved the pulp.

My experience has led me to believe that it is simply impossible to have an *unfilled tooth* decayed to such an extent that the pulp is almost involved, without such a cavity being readily disclosed to a well trained eye.

Dry that region, examine the tooth with a mirror, and it is surely impossible for the large decay *not* to give the usual reaction to the eye.

Do I never let cavities get by? Foolish question No. 7015. Who is a hundred per cent perfect? But when it *does* get by, it's because I fell down on my job and fell down good and

hard, and that's all there is to that.

I really believe that a dentist who has a patient come to him from time to time for an examination, and allows a cavity to grow until the pulp is nearly exposed, never would have discovered *that cavity* in its incipiency by means of the ray.

But the very worst feature of this radiographic business is the *neglect* of the teeth that its most ardent advocates advise.

Dr. Raper, himself, says that this examination should be made "once a year, until the age of thirty; thereafter, perhaps every eighteen months, or bi-yearly, unless there is particular susceptibility or certain lesions the operator wishes to keep under more frequent observation."

Dr. Thoma in *Ward's Text-Book*: "Yearly in young patients and eighteen or twenty-four months in patients over thirty years."

I don't know anything about your practice, my dear Doctor Weber, but I value my own teeth so very much that I have them examined at least four times a year (please bear in mind that the Chicago boys gave me a birthday party in 1926, and there were seventy candles on the cake) and I haven't—of course I haven't—a dead pulp in any tooth that chewed that cake. My wife, my daughter, my son-in-law, my granddaughters, all get at least four examinations a year. My young lady assistants in the office, the same, of course. My patients get two, three, or four, according to their needs.

What *dentist* (Raper and Thoma are not practicing dentists, bear in mind) of any standing, will come out and tell us that he examines the teeth of his little folks once a year, and for older patients once in two years? Why he'd be ashamed to say that, even if it were true.

If a dentist examines a patient's teeth only once in twenty-four months, then he certainly does not do any work for him any oftener, because he cannot do any work upon them without examining them. And examination once in two years!

Now then, while the advocates of the x-ray examination must well know that good practice *demands* more frequent examinations of the teeth than they advise, why do they advocate their raying only every twelve to twenty-four months? Well, the answer to that is dead easy. No patients would stand —I mean pay—for this examination three or four times a year—and that's no joke!

Now "listen in" on this, Dr. Weber, and you too, "kind reader." If an x-ray examination is really necessary in order to discover small cavities, then this examination has just got to be made just as often as is necessary — there's no gainsaying that.

So, Dr. Weber, if you really have recently learned (as you say you have) that you can't examine your patient's teeth properly without raying them,

then every time you examine them you are in honor bound to use the ray—there's no getting around that, is there?

You started your article with a question, Dr. Weber. Now I will close mine with one. Are you going to follow Raper and examine the teeth of your patients, "During early life, I should say, every year for the *average class*" [italics mine], "After thirty, every eighteen months or two years, unless there are some *particular lesions* [italics mine] that the operator wishes to keep under more frequent observation"?

There you are Dr. Weber. Are you pleased to consider that kind of service to be satisfactory service? Maybe you, like Dr. Raper, may consider it such, but I can assure you that there are lots of dentists who would not for one moment consider letting their little folks go one year without an examination, and their older patients as long as two years—I can assure you of that.

Don't you realize, Dr. Weber, that the whole trend of the times for better dentistry hinges upon frequent prophylactic sittings and the *frequent examination of the teeth for caries?*

In conclusion, I have this to say: Every man should have the privilege of running his practice to suit himself. Anyone who realizes that he cannot find cavities in the usual manner, and considers it either necessary or advisable for him to use the x-ray examination, certainly should use it.

If the advocates of this examination would say: "We *never* find it necessary to make a full mouth examination. We never ray the lower incisors and rarely, indeed, the upper incisors. We never ray *visible* surfaces. We use the ray with judgment, and as for the frequency of an x-ray examination, why, of course, we have to ray some teeth in some mouths every three or four months"—if they would only talk that way, well then there would be something in it—that there would.

As for myself, "once in a blue moon," I discover a cavity upon the proximal surface of a tooth and extending under the gum line. *After its discovery,* believing that possibly I can get a "line" on its extent under the gum, I ray it. This skiagraph is *not necessary,* but it might help. Under these circumstances, I never make a charge for that film. That's my practice.

Right now I believe that superficial decay should be polished off as soon as discovered; that no cavity is too small for filling; that superficial decay and approximal small cavities cannot be disclosed upon a film, and that the only reliable method of examination is in the old-fashioned way.

"Is Dr. Kells always right?" I trust my reply has been satisfactory, and now, Dr. Weber, I await with interest your replies to my return questions.

MINNESOTA— as a Playground

IN the heart of the convention city, Minneapolis, is one of the best known attractions of the state, Minnehaha falls, immortalized by Longfellow's poem, Hiawatha.

Within a couple of hours drive by automobile from Minneapolis will be found the Dalles of the St. Croix River, considered one of the outstanding scenic attractions of the north country. It is said that at one time great glaciers blocked the present outlet of the Great Lakes at Niagara and that the water of Lake Superior flowed down the St. Croix valley to the Mississippi.

Every evidence of this great river remains. Curious stones, worn to various shapes by the swirling waters of thousands of years and pot holes dug in solid rock to a depth of 80 feet are among the attractions that may be found there now. Among the rocks that are viewed with interest by thousands each year are the profile rock known as the Old Man of the Dalles, the Devil's chair and a group of rocks which constitute the Devil's kitchen. At the bottom of the ravines flows the St. Croix River, dyed a deep coffee color by the roots of the cedar swamps and iron ore near its source. The rocky bluffs and hills that hem the river in are heavily timbered with pines, birches, maples, elms and oaks.

Becoming known in recent years as one of the most beautiful drives in all the world is the Lake Superior International Highway which extends along the north shore of Lake Superior from Duluth to the Canadian city, Port Arthur. This highway extends through wild rugged country all the way and is considered second to none in the United States, as far as scenic attractions are concerned. It is in almost constant view of the lake, although at times it swings out into the forest for short distances. Pine forests extend to the very lakeshore most of the way, while innumerable rivers tumbling down from the rocky country to the north and west cross the road every few miles. There are some beautiful waterfalls and a great abundance of wild life to be seen here.

At the northern boundary are two interesting lakes, Rainy Lake with 1,000 islands and Lake of the Woods with 14,000 islands.

Just north of the mining country will be found the Superior National forest, established during the presidential administration of Theodore Roosevelt and recognized today as being second in importance

only to Yellowstone Park among the scenic playgrounds of the nation. This forest with adjoining forests owned by the state of Minnesota covers an area of approximately 2,500,000 acres. It extends to the Canadian boundary, and then to the north lies another great forest owned by the Dominion of Canada and known as Quetico Park. The two constitute a great international playground. There are no roads in the Superior National forest and the only means of transportation is by canoe. It is the greatest canoe country on earth and in recent years thousands have taken canoe trips through this northern labyrinth of lakes. Wild life is abundant here. Moose, deer and bear as well as other animals now becoming scarce throughout most of the United States will be found here and the lakes are full of fighting game fish.

In the north central part of the state the Minnesota National Forest, a preserve of 312,000 acres; the Red Lake Indian reservation with its virgin forests and Itasca state park, enclosing Lake Itasca the headwaters of the Mississippi River are places that are sure to appeal. At the Red Lake reservation and the vicinity of the Minnesota National Forest there are still some of the old pagan Indians, who refuse to follow the ways of the white man; who worship their pagan gods and place little huts over the graves of their dead where money and food are left for the use of the spirits of the departed ones. There are only a few of these old fellows left. In their places are growing up young college-bred Indians; the girls with their bobbed hair and modern manner of dress and the boys with their balloon trousers, yes, and hair oil, making a strange contrast to the older members of the tribe. The old fellows, content with the customs of their fathers, live in a little Indian village on a peninsula dividing upper and lower Red Lakes and seldom leave their little huts except to hunt or attend an occasional celebration at the agency.

Extending through the heart of Minnesota lies a group of excellent lakes. The western part of this territory is known as the Lake Park region and the eastern part as the Mille Lacs and Leech Lake region. The Lake Park region is timbered with deciduous trees. The other territory extends from the decidu-

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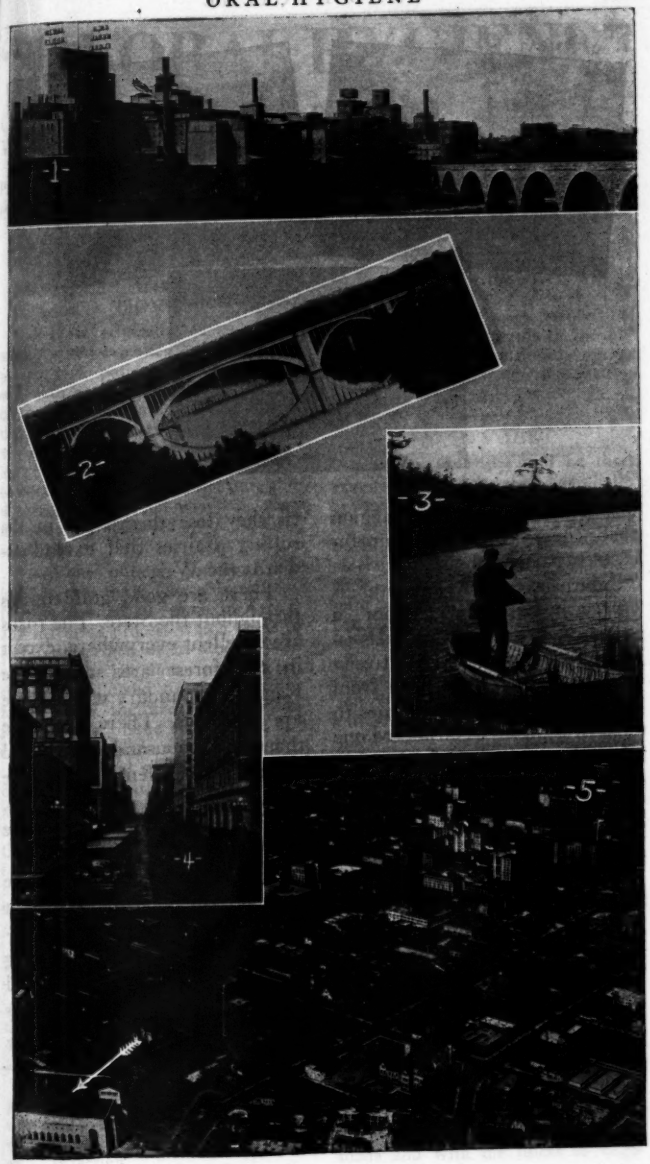
1.—*The largest flour mill in the world—Gold Medal flour is made here.* 2.—*Beautiful bridges span the river.* 3.—*Thousands of lakes adjoining Minneapolis make Minnesota a fisherman's paradise.* 4.—*Nicollet Avenue which is Minneapolis' Fifth Avenue.* 5.—*An airplane view of down-town Minneapolis. The arrow points to the Auditorium where the convention will be held.*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ous area to the great pine region that covers the entire northeastern part of the state.

Southeastern Minnesota is especially attractive from a scenic viewpoint. The Mississippi River as it flows between Minnesota and Wisconsin from a point near the Twin Cities to the Iowa border is considered one of the most beautiful places in the West. High bluffs hem in the river on both the Minnesota and the Wisconsin side and a beautiful driveway has been built along the bank of the river from LaCrosse to the Twin Cities. West of the river lies the country known as the Bosky Dells where the great bluffs diminish in size, like the waves in the wake of a mighty ship until they lose themselves in the rolling prairies that extend towards the West.

There are good golf courses throughout the State. The roads are excellent everywhere, except in the forest area along the Canadian boundary where there are no roads. There are more than ten thousand lakes and fishing is excellent. There are many very good trout streams.

This, we believe, will give you some idea as to what Minnesota has to offer. The State has, of course, anything that would be desired in summer vacation accommodations from big summer hotels with every kind of entertainment to log cabins secluded deep in the woods.

"*Ask* ORAL HYGIENE"

Conducted by V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Bldg., Denver, Colo.

Please communicate directly with the Department Editors. Please enclose postage. Questions and answers of general interest will be published.

ABSCESSES AND EXTRACTIONS

Q.—Is it advisable to extract a tooth when swollen condition is present? A patient presented himself with such a condition and upon extracting the tooth a great quantity of pus was expelled. Is there any danger of further infection taking place? If so, how? Would it be best to first drain off the pus, and if so so, how? What would be your method of procedure?—N.C.S., Chicago, Ill.

A.—Your question of the 12th inst., is that of a debatable subject. It is contended by some men that any infective process which tends to be circumscribed or in other words which tends to form an abscess, should be allowed time for Nature to wall off the area of infection from the rest of the body before operative procedures are instituted.

Many general surgeons and some dentists contend that a tooth should not be extracted when there is an acute alveolar abscess surrounding the apex of this tooth. They maintain that palliative measures should be used until Nature has had time to wall off the infected areas from the rest of the body.

Their contention further is that if the tooth is extracted before this walling off process takes place that it is likely to result in a spread of the infection through the tissue opened up by reason of the tearing loose of the tooth.

However, after thirty years' experience I can say that I have never seen bad results from the removal of a tooth in the early stages of acute infection.

I have felt that the surest way to drain the abscess cavity is through the socket of the tooth responsible for the abscess. It seems to me unnecessary to make a double operation by evacuating the pus first.—George R. Warner.

CHILD'S DIET

Q.—The little girl will be three years old next June. She has all the appearance of being healthy. All of the child's upper teeth are decayed. Large cavities are present in the posteriors. A very dark coating is present on all of them. Teeth are solid and until today never bothered her. All the lower are pearly white without decay. The Mother said a dead son had the same when four years old. This son died when five. The little girl is using the bottle and drinks canned milk, very little other food. Orange juice cramps her. Until I hear from you I suggested a little orange juice at a time to again see the result, plenty of outdoor exercise, the use of cow's milk, discontinuing the bottle, a diet of green foods, very little sweets.

She has just passed through a little stage of the flu and has taken but little medicine. I would be pleased to hear from you, being young in the profession and have a desire to know what this is all about.—J.F.B., Williamstown, W. Va.

A.—In reply to your letter of the 3rd inst., would say that you have a very good conception of the underlying principles in treating the case which you submit, and I believe if you persist with the green foods and with the juices of vege-

tables that she will eventually reap the reward of your intelligent care.

The "pot-liquor," i. e., the water from boiling vegetables, contains a high percentage of mineral salt in an available form and can be seasoned and used for food for infants. If the orange juice cramps her I would discontinue it, she may have an idiosyncrasy for it. Some people cannot use oranges at all.

The best local treatment in these cases is powdered silver nitrate applied freely and frequently to the carious or disintegrating areas on the teeth. If used early enough and persistently enough the progress can be somewhat controlled and the teeth can usually be retained until about the normal time for their resorption.—George R. Warner.

ARSENIC NECROSIS

Q.—A boy 12 years old, recently came to me with a necrosis I believe caused from an arsenic treatment. The upper first molar was quite loose as the process and underlying tissue were a dull grey. I broke down same process and irrigated well. For some time the boy did not come up to the office and yesterday came again; the process was eaten pretty badly and a large hole was eaten in the tissue and surrounding process.

I gave him an appointment for tomorrow and intend taking out same necrosed process, irrigating it and then packing.—R.D.S., Cheyenne, Wyoming.

A.—It is essential in arsenical necrosis to get rid of the arsenic, which of course is very difficult to do in a case which has progressed as far as the one you report.

Ordinary whiting or precipitated chalk will usually pick up the crystals of arsenic if they can be put in contact with the crystals. It is therefore good treatment to pack the areas well with a dry whiting or precipitated chalk then wash them out. Where the arsenic has caused necrosis and sloughing it is wise to pull away the sequestrum then pack the area underneath with the powder. I had one case of a boy five years old in which arsenic escaped from a second deciduous molar and caused the loss of the first permanent molar and all the adjacent alveolar bone, but by the procedure outlined above we were able to keep it from going deeper.—George R. Warner.

PYORRHEA INJECTIONS

Q.—In pyorrhea cases some dentists resort to injection into the gum. What solution is used and where injected?

Besides scaling of teeth is there any dependable medicament that can be used in the treatment of bleeding gums? — E.D., Jamaica, N. Y.

A.—Some years ago Emetin, an alkaloid of Ipecac, was injected in the gums in cases of pyorrhea as a curative measure. It is my belief that this practice has been altogether abandoned.

I do not know of the use of any other medicament, hypodermically, in the treatment of pyorrhea.

If scaling is thoroughly done, traumatic occlusion relieved, if the home care is efficient, there will be no need of the use of a medicament in the treatment of bleeding gums.

If these other three measures are not well carried out, medicaments will be of no value.—George R. Warner.

CHECKING X-RAYS

Q.—I am sending to you several x-ray pictures for diagnosis.

I refer specifically to the artificial crowns—the one, a hollow metal, and the other a Richmond crown.

To check up for a skeptical patient I am asking you to give your diagnosis of these two crowns, or rather the condition of the periapical areas.

Also please criticize the x-ray pictures in general as to technic if there is criticism to be made.—E.W.H., Natrona, Pa.

A.—The only thing I would say in regard to the technique of your radiograms is that the angles are a trifle high. The central incisor shows some evidence of at least an inflammatory condition in the pericementum and some thickening of the lamina dura.

I believe there has also been a change in the cementum itself, there appears to be a roughening indicative of either a past destructive action which has stopped, or one which is progressing. The former would seem a little more likely considering the thinness of the pericemental space.

In the area of the missing lateral incisor there is some foreign material, probably filling, with enough radiolucence surrounding it to be indicative of the possibility, if not the probability of infection. Around the cuspid root there is some change in the pericementum and alveolus. This change might be due to traumatism, to a non-vital pulp or to an irritated vital pulp.—George R. Warner.

BURNING DENTURES

Q.—Some time ago I made a full upper and lower Porcelite denture for a lady, who complains of the upper denture having a drawing and burning sensation. She says she can only keep the denture in her mouth for about six hours at a time when she must remove it for a while. Have you ever heard or known of Porcelite acting or causing similar sensations for any one else?—H.O.E., Mansfield, Ohio.

A.—I do not believe that the Porcelite is the cause of this burning sensation, although some operators do think that it really does act as an irritant in some mouths. There also seems to be evidence that vulcanite cannot be worn with comfort by some patients. It is my opinion, however, that this burning sensation is probably due to nerve pressure—most likely at or adjacent to the anterior palatine canal. It is less apt to be caused by pressure over the posterior palatine canals, as a much deeper layer of resilient tissue over-lays the nerve and blood supply in this region.

Pressure on either or both of the metal foramina may cause such a reaction, although pressure here is more apt to result in numbness or neuralgic pains.

If you are unable to correct this discomfort by relieving pressures, it would be well to switch to metal bases — preferably gold, although you cannot promise positive relief even then. Some patients seem to be doomed to more or less of this type of discomfort in spite of everything that we dentists can do for them.—V. C. Smedley.

We will greatly appreciate experiences and opinions of other operators bearing on this extremely troublesome type of case.—V. C. Smedley.

ROPY SALIVA

Q.—Patient, female, 24 years old, has thick, ropy saliva, so thick that in drying a cavity with cotton it will adhere to cotton and stretch like gum or rubber.

She has trouble with inlays and fillings lasting any length of time. Another dentist has made some of the inlays and fillings as many as three times. I would like to do some work that would last.

Do you think the condition of the saliva has anything to do with it?

What treatment would you suggest?—A.N.R., Eldora, Iowa.

A.—This thick ropy condition of the saliva probably has a lot to do with the tendency to decay in this patient's mouth.

This saliva viscosity can best be corrected through a well regulated change in diet, and with its correction the unusual tendency to decay will undoubtedly be checked also—if the patient will adhere to the corrected diet sufficiently faithfully to maintain the saliva at normal.

Have patient eliminate heavy starchy foods, such as bread and potatoes. What bread is eaten should

be whole-wheat and thoroughly baked. Raw fruits and vegetables should be partaken of freely, and any of the non-starchy cooked vegetables are good. Meat or other strongly proteid foods should be taken not more than once a day.

I should be very pleased to hear from you—whether you are able to get this patient to follow such a diet, and if so whether the desired condition of the saliva is obtained. —V.C.Smedley.

BITE RAISING

Q.—I have a patient as follows: Young woman, age 24, upper anterior teeth completely cover lower anterior teeth. It is so marked that depressions are caused in lower gum labially and in upper gum lingually.

There are no teeth missing; the 3rd molars have all erupted. If continued pathologic conditions of the gums will arise.

Please suggest method of raising bite or any other course to be taken. —A.K., Brooklyn, N. Y.

A.—In reply to your favor of 6th instant, I think that bite raising should be quite frequently done in every up-to-date dental practice, and for this patient you describe it is evidently very important that it should be done rather promptly.

The degree of opening and the proper balance of the occlusal planes should first be established with an interdental splint or interdental splints. In this case, undoubtedly, occlusal splints for both jaws would be necessary to establish an occlusal balance. These may be made of vulcanite covering the occlusal surfaces of the teeth and the palate; or to cover just the occlusal surfaces, being retained with wire clasps fitted to molars or bicuspids.

These splints can be tried in in the wax stage, and the proper occlusal balance worked out before vulcanization. It is possible to cast these interdental splints of hard gold and let them be worn indefinitely, but it is preferable to build all of the teeth up or down, as the case may be, with properly fitted and contoured crowns or gold inlays or bridges as the condition of the individual teeth may indicate.

It is frequently necessary in order to secure a balance of the bite (which is quite as important in these open bite cases as in the most successful full denture work) to grind elongated natural teeth, such as I judge the anteriors in this case to be.

Where the bite is to be restored with inlays, crowns, or bridges after the occlusion balancing interdental splints have been set and worn for several days or weeks to establish the correct muscle habit of the individual, sections of the vulcanite can be cut out after the various inlays, crowns, and bridges are made and set.—V. C. Smedley.

REMOVING STAIN

Q.—I have a patient who is troubled with very dark stain around her teeth. She is 20 years old, very fair, and certainly does try to keep her teeth clean. I am in hopes you can suggest some home treatment so the stain is not so difficult for me to remove. Would thank you for a reply.—T.U.C., Easton, Maryland.

A.—Dark stain on the teeth is usually due to some disturbance or abnormality of the digestive tract or to unusual or unnatural habits of eating or combinations of food.

It would be well therefore, to first go into the matter of the diet and if the diet proves to be reasonably normal or usual it would be necessary to account for the effect rather than the cause.

If ordinary dentifrices will not keep the stain off when used with a dry brush, then the following powder will be found to be efficient:

Beta Napthol, 10 grains; Precipitated Chalk, 4 ozs.; Oil Gaultheria, 10 drops; M. et Sig. Use on dry brush as tooth powder.—George R. Warner.

Fads & Observations

By J. Martin Fleming, D. D. S.,
Raleigh, N. C.

CONCLUSION

POSSIBLY more fads have been followed in the treatment of pyorrhea than in any other branch of dentistry. We had one remedy which when applied to the teeth would absolutely dissolve all deposits and we believed it—we seem ready and anxious to accept anything if it's advertised sufficiently and kept constantly before us—we are anxious to find something that will lighten the burden of practice—always trying to get something for nothing. It is a trait that seems inbred—Emetin came along—we swallowed that hook, bait and sinker—we think of it now as an absolute failure and yet it probably caused many of us to take up the treatment, because it offered such inducement of success, but when we found it a failure we had already put our hands to the plow and we didn't look back. The consequence has been much good work along pyorrhea lines by dentists all over the country, who never would have attempted it at all but for the Emetin fad.

It even caused physicians to take some interest in it. I know of one, who, when Emetin failed, turned to the violet ray and seemed surprised that it did not cure. However, he soon came to a fundamental observation, that there could be no cure until the scale was thoroughly removed by instrumentation. He then went to a dentist and at first tried to borrow scalers but was finally convinced that some skill was necessary in their use, and so turned the patient over to the dentist. However, he was not far from the truth when he had decided on the necessity of thorough instrumentation. That is one thing that has been fully demonstrated in the failure of each pyorrhea fad, and following thorough instrumentation almost any treatment is good, especially that looking to the proper massage of the gums with a stiff brush—remembering that it is a disease of the gums rather than the teeth. I do not mean to criticise the violet ray, it probably has its place, but I wonder if a short time will not be sufficient to lay it among other electrical appliances in the back room.

ROOT CANAL WORK

When it comes to root canal work we come again to a most fruitful source of fads. During the last five years we have filled the root canals with iodoform, we have filled them with creo-

sote, we have filled them with formaldehyde, eucalyptus, wax, cement, gold, amalgam, gutta-percha, we didn't fill them at all, we mummified them, we overfilled them, we put a button on the end of each root, and showed it as proof that we were fine operators (and we were, for that is not always easy). Then we gradually leave these fads of ours and out of the experience gained we attempt to standardize some one method, but the standard of today becomes a passing fad of yesterday. It is only just, however, to say that the filling of chloroform, resin and gutta-percha as advocated by Dr. Callahan has probably saved more dead teeth than all other methods of present-day treatment. If it is a fad it has stood the test better, and possibly longer, than other fads have done.

HYPNOTISM

Some years since, a leading physician of our State and town advocated hypnotism in dental work, especially in extracting. I don't mean that he was the only man to advocate it, there was a wave of it all over the country, but this case came under direct observation.

At a meeting of the State Dental Society, about nineteen hundred, this physician demonstrated his hypnotism before the society and brought his patient who submitted to having all his teeth out without once batting his glassy-looking eyes.

This one clinic made so much impression on one dentist that he came to Raleigh to have the physician hypnotize him and his wife for the extraction of some teeth and it proved a perfect failure. I can hear the physician now droning, droning, droning, the one sentence "You will feel no pain, you will feel no pain, you will feel no pain," until it really became monotonous, and then as the dentist started to extract the fellow raised up and said, "The hell I don't!" That ended the demonstration and signalized the passing of the fad in Raleigh. The fad had one other fatal drawback: you had to pick your patient as well as your hypnotist. It is seldom you have both together at one time, all are not hypnotists, neither can all be hypnotized.

It might be interesting to you to recount one other local fad which furnished us some amusement in North Carolina—one of the brightest men we had in the State conceived the idea that a serum could be manufactured from the poison of a rattlesnake with which you could innoculate a person and absolutely prevent decay in the mouths of those innoculated.

Why he chose the rattlesnake poison I do not know, but he argued that if innoculation was successful against smallpox, diphtheria, typhoid, and such diseases, it could also be used against tooth decay. It was just a fad with him, but to show you to what extent his enthusiasm carried him, he prepared a paper and read it at the meeting of the Southern Society in Birming-

ham and a newspaper of that city featured it as one of the leading papers read before that convention and carried a large picture of its author. The Southern Association was noted too for its conservatism, and by way of parenthesis let me say that many of us who belonged to that organization, when we see the bulkiness of the American, are sorry that it is no more. But to come back to the serum. The doctor did not attempt to work out the details himself—he mentioned another doctor as possibly being the best equipped man to make the research and to make it a success. At least he recognized the fact that only research men could do that.

Sometimes this very matter of research becomes a fad with us and lots of unnecessary time is lost in covering ground already covered. Research as carried on by men especially fitted by training for that work saves time and labor. The great and outstanding progress along research lines will come through these men specially trained. In this research work it is difficult to single out the men doing the best work—we all know of the work being done by Rosenow of the Mayo clinic and of that done by Dr. Weston A. Price and others. Probably as great work as any is being done by Dr. Percy Howe of the Forsyth Infirmary at Boston in his research along diet lines. He certainly is not pressing his fad for revenue and his ultimate success in discovering something tangible seems assured, in spite of what we may believe about this monkey business. His work along diet lines certainly is in contrast to that of the so-called "Defensive Diet League," which was so well exposed in the *Journal of the A.D.A.*

Aside from fads in the active practice we have other fads of policy and possibly of law and of ethics which come in and really blind us to the other person's viewpoint. I speak principally of those things which arise in North Carolina, but our two states are so closely associated along these lines that we both face practically the self-same problems.

The dental hygienist for instance. In our State we have those who really seem to think that if the legislature does not license these "lizzie dentists" that the whole fabric of the profession will fail. They say we need them for educational purposes—that we will never know the importance of the teeth until told by those hygienists—those who have taken a one-year course, ready to teach and clean teeth and do any other operation in the mouth that unscrupulous employers might see fit to ask them to do. You may judge from these words that I am opposed to the hygienist but I am frank to acknowledge that I was afraid that I too might be wrong and that my enthusiasm against them might have become only a fad with *me*. But at the last meeting of the National Board of Dental Examiners the

president of that organization recommended in his address that so far as possible the duties of the hygienist and the regulations governing her practice should be more restricted.

He made the assertion that those states, in which their practice was not allowed, were better off and that they should be slow in going into a scheme so full of possible danger. Danger of their not confining their practice to the field granted them, but gradually overstepping until they were changing treatments and inserting simple fillings, the detection of which is almost impossible.

It has always seemed to me to be a fad for revenue if you are anxious to have some one working for you. It is an effort to swell our own receipts by the sweat of someone else's brow—a female brow at that. If you will notice you will find that their enthusiasm for the hygienist wanes whenever you begin to tell of separating her work from a dental office—making it an independent profession or of initing it to school work, under the State Board of Health. Most advocates of the plan lose all interest then, and that makes you wonder if their original interest was not a selfish one.

The statement in regard to the hygienists met with much applause and it came too, from states now having the law. California especially spoke of the situation. They said there were only forty-five licensed hygienists within the State, yet every advertising dental parlor claimed to have one of them, when really none of them had one. Yet they advertised it just the same and it was well nigh impossible to catch one because they are shielded in those offices. The men who run them are anxious to see all dental laws fail. They could then openly employ unlicensed men.

The recognition of the hygienist would certainly cause us trouble in North Carolina and we class it as a fad rapidly passing there as it has already passed in other states.

Another fad or habit which seems to have taken hold of us is the habit of thoughtlessly criticising some other man's work—absolutely forgetting that in so doing you are violating one of the fundamentals of our code of ethics, claiming superiority over a fellow practitioner.

In each such criticism there is the veiled suggestion that you could have done it better.

In the present day of the shyster lawyer and his ever-present damage suit, it should be our endeavor to use the utmost care in speaking of another's work. It is so easy to let slip some word or phrase which can be misconstrued till a mountain has been made out of a molehill. I dislike to see a collection of old bridges and crowns, mounted for display, to show what sorry work some fellow practitioner is doing. There is no more justice in it than if you went to an automobile junk pile on the edge of town and chose some worn-out

automobiles, mounted them for display and called attention to them as a fair sample of what was being put out. There is no justice in it. You forget that the crown and bridge work you show has probably served its day and generation just as the worn-out automobile has done. You cannot compare a stubble field to a ripe harvest. You cannot compare the worn-out product with the new. You don't know what it looked like when new. You don't know if chemical or mechanical abrasion may be responsible for the poor fitting crown.

We don't know all the circumstances of its construction and life, and we should be slow to criticise.

In following this course we have to shut our eyes to some inferior work but we ourselves are not the gainer by criticism, while the profession is a heavy loser. When it comes to the other man's work it is safe to follow the motto of the three wise monkeys—"see no evil, hear no evil, speak no evil."

We too have our personal fads, golf, football, baseball, gardening, walking, horse back riding, hunting, fishing and others too numerous to mention. We should have no word against them—they are all good, each should be encouraged.

Following a fad gives only pleasure and relaxation, and if one profession more than another needs relaxation, it is ours. So cultivate outside fads, but when it comes to professional fads be careful that the pursuit of your own does not lead to the intolerance of your neighbors'.

In conclusion please let me say that if this paper seems in the least to criticise or ridicule some other man's fad, even in the smallest way, it is not so intended, nor do I think we should have a pessimistic view because so many of our professional fads are failures. We get something out of each one, and when you look back over a period of thirty years of practice and compare "the then with the now," we can easily see that much progress has been and is being made. As we grow older and our more mature judgment comes to the ascendency we find more and more men working not "for revenue only" but for the sheer love of humanity combined with the love of their work, in an earnest effort to serve. When we do that, in its fullest sense, we are not far from the full stature of attainment.

INTERNATIONAL Oral Hygiene

By Chas. W. Barton
Overseas Editor

GREAT BRITIAN

In recent reports on the public dental service in Great Britian certain questions stand out as, either worrying those in charge of this service, or indicating a new trend towards a broader view of the aims of public enlightment in oral hygiene. The former question refers to the frequent refusal, in some localities, by parents to send their children for dental treatment, while the latter question is bound up intimately with the problem of diet as the primary means for the prevention of caries.

The report of Dr. W. Baird Grandison, the Public Dental Officer for Cambridge, for the year 1925, shows that during the year under consideration 6,217 children were examined, of which number 2,266 had sound dentitions, the girls coming out somewhat better than the boys. Of the remainder 2,702 received treatment, and 1,249 required treatment but did not receive it, mainly because of objections by the parents. In reference to such objections Dr. Grandison says: "It has frequently been urged that parents should be invited to attend the dental inspections, in order that the officers responsible for the treatment may offer explanations and give advice, in the hope that existing prejudice may be satisfactorily broken down, and the numbers accepting treatment required consequently increased. I am not in sympathy with this point of view, as, though the motive is quite sound, one must not forget that a prolonged period of inspection at the schools causes not only a temporary dislocation of the educational services, but the officer concerned has a large quantity of actual dental treatment to complete within a specified time, work which demands quality of workmanship, and he could therefore be better employed in the clinic, where parents could receive all the necessary advice and instructions and, in addition, actually witness the accomplishment of the work, should they so desire. Inspections should be dealt with in the minimum of time coupled with the maximum of efficiency, and experience proves the following method to be satisfactory to all concerned: 'Examine children with sound teeth thoroughly and the remainder casually,'—by this means it should be possible to complete over 100 cases per session."

We beg to disagree with the doctor as to the logic of the above statement, and wish to refer our readers to a recent issue of ORAL HYGIENE where the success of

parental instruction has been reported from Holland. Dr. Grandison, however, has some very sound ideas about problems of diet. After stating the case against our present day foodstuffs, he goes on to say that "obviously, therefore, we are confronted with a problem requiring solution and drastic action. Good sound teeth are essential to health, incorrect dieting tends more than anything else to rob the individual of this very necessary adjunct to health, and yet the position of the dental officer with regard to the subject of diet is, to say the least, very difficult. He knows perfectly well what to recommend for human consumption and what should be avoided, but by virtue of his being entirely unacquainted with the medical history of the individual, past and present he may, very probably will, recommend various articles of foodstuffs which have been repeatedly condemned by the members of that profession whose privilege it is to know and to understand their patients' powers and limitations. When, therefore, it is intended to recommend any substantial alteration in the diet of the individual the same should unquestionably originate from the members of the medical profession, and we dentists should content ourselves by respectfully intimating our recommendations to that body for their earnest deliberation."

In the matter of refusals on the part of parents to send their children for treatment to the school dental clinic Dr. Arthur J. Percy, of Taunton, has made comparisons between the number of refusals in Birmingham and his own city. In this former city, according to the Medical Officer's Annual Report for the year 1924 on dental treatment, the percentage of such refusals amounted to 54 percent of the appointments sent out, while in Taunton out of 3,148 appointments but 26 percent failed to attend for all reasons. "One realizes," says Dr. Percy, "that to gain the confidence of the children and the interest of the parents in dental treatment has been, and still is to a certain extent, an uphill fight; but with the kind treatment and consideration which is at all times meted out to the children and their parents this difficulty is being overcome. Certainly this year we have had many attendances from those who have never been before." Diet has impressed itself upon the doctor's observation especially inasmuch as "the increasing number of ill-developed jaws is becoming more noticeable every year, the inevitable result of this being irregularity of the permanent dentition. This ill-development is brought about in some cases by the presence in the mouth of decayed and painful teeth, acting as a deterrent to efficient mastication, and in others by improper diet in early childhood, giving insufficient work for the jaws. Parents who attend the clinic are always advised as to the importance of this and as to the type of food their children should be given."

* * *

The Devon Education Committee at Exeter discussed recently suspected attempts to evade the dental examination of school children, and the Medical Sub-Committee were instructed to consider, in case of refusals, the question of asking for a certificate from the child's own dentist. One thousand refusals had been reported. It was thought that these refusals should be followed up by the authority, and that any child who refused to be examined or treated by the county dentist should be required to show a certificate from its own dentist. Is was understood that there was no difficulty in granting such a certificate to the parents, but it cound not be supplied to an outside person or body. The legal power of the Committee to demand such certificates was questioned, but is was stated that they had absolute power to require medical certificates in any case they considered necessary. *The British Journal of Dental Science.*

A peculiar situation has developed at the Devon and Exeter Dental Hospitals where applications to the hospital for dental assistance were fewer than formerly. The hospital, it has been stated, was capable of doing much greater work for the community. There was great competition nowadays, private practitioners had increased and the schools were running dental clinics, but it was claimed that the dental hospitals did nevertheless fill a niche in providing important treatment, and doubtless as time went on there would be more demand on the institution. During the year 363 cases were treated, a decrease of 80 on the previous year. The dental staff was at full strength, so that patients could be treated each week day. *The Dental Magazine.*

* * *

A somewhat startling suggestion, according to the *British Journal of Dental Science*, was made by Dr. T. B. Layton in a clinical lecture delivered at Guy's Hospital and reported in the *Lancet* for September 4th, 1926. He was discussing focal sepsis in its rhinological aspects, and after reviewing other sources of infection in the nose and throat he dealt with dental diseases. The lecturer enumerated periodontitis, opical suppuration and general caries of the teeth, of which he appears to consider the last as the most important of dental sources of infection. He went on to say, "In deciding whether the tonsils should be first removed or the mouth made edentulous, the former may well claim priority unless the evidence in favor of the latter is overwhelming. It is a great loss for a patient to have every tooth removed.... Further, the very plates the dentist makes may themselves act as a source of sepsis as much as the teeth he has previously removed. I am not yet sure that this is so, but I shrewdly suspect it, and I ask you to follow up this train of thought and see whether you can get evidence on this point." We are not ourselves aware, says the *Journal*, of any evidence on the point, we rather imagine that it has been considered superfluous. It certainly seems difficult to imagine that a denture, which can be taken out bodily and cleaned as well as immersed in antiseptic fluid, can be guilty of being a source of focal infection, whatever may be its other vices. Undoubtedly many dentures are not subject to very vigorous cleaning, but we doubt whether even the dirtiest denture can be as serious a menace as are the natural teeth in even the mildest case in which extractions are performed for the eradication of a site of infection. For one thing, the denture, unlike the natural teeth, is not connected with the blood stream, which is the most direct way for the conveyance of infection in such cases. However, the question has been raised, and it might be as well to get "evidence on the point."

Is this, asks ORAL HYGIENE, the twentieth century, or is it a deft joke?

ITALY

At the XV Italian Stomatological Congress in Perugia, in August, vaccino-therapy in dentistry furnished the subject matter of several papers. Dr. C. R. Amoretti, of Imperia, has experimented with vaccines for three years in numerous cases of purulent infections of the mouth and in pyorrhea. In cases of osteitis, periodontitis, and fistulae the result has always been very gratifying. In cases of pyorrhea a vaccine should be considered merely as an adjunct to perfect instrumentation and the removal of all necrotic tissue; its chief value lies in the ease with which it is possible to overcome suppuration. Dr. D. Dalma, of Fium, has been using the vaccines Inava B. and brodovaccine Gremy in about 300 to 350 cases of periodontitis of which he presented six to the meeting. The application of vaccines takes place in the root canals and by inoculation around the apex of the affected tooth. The results were remarkably good, with complete recovery of the affected

teeth. The cure has been verified as continuous one year after treatment.

Dr. P. A. Albanese, of Castello, has inaugurated a method of treatment for caries by means of vaccines, mixed and polyvalent, on the basis of Besredka's theory of local immunization. In third degree caries the vaccine is applied after pulpectomy and the canal filled immediately. The result is always good. In fourth degree caries with fistulous opening the administration of a vaccine effects rapid procedure inasmuch as the fistula closes promptly and the canal can be filled definitely after short treatment.

* * *

Dr. Ramiro Cozzi, of Trieste, reported on the school dental service in that city, instituted two years ago as reported in ORAL HYGIENE. The municipality has contributed 30,000 lire, while 5,000 lire were assignated by the Ministry of Public Instruction and an equal amount by the Ministry of the Interior. Two ambulatoria were organized for the schools in the outlying districts of the city. While with the hospital clinic an attendance of 80 percent had been possible, with this mobile service 100 percent of the children could be attended to; 4,538 treatments were carried out, 4135 extractions of temporary and 528 of permanent teeth, 5824 permanent fillings and 96 temporary fillings, in addition to 253 miscellaneous treatments. All the children of the first and second grades were examined and treated, and next year those of the third grade will be called to the dental clinic for the first time, while the former two categories will be re-examined and re-treated, so that eventually all the children will have come under dental care. *La Stomatologia.*

BULGARIA

Among 378 children between the ages of 11 and 15 frequenting the school "Sts. Cyril and Metodi" in Sofia only 25 percent showed sound teeth. No more than 18 percent received dental treatment. 47 percent claimed that they cleaned their teeth regularly, 28 percent only now and then, and 25 percent not at all.

* * *

Dr. L. Zoubow has made an interesting inquiry into the relative state of the dental health among people in the city and the peasants living in the country. He examined 2,300 persons, of whom 1,300 peasants (900 between 25 and 50 years of age, 400 children and youths between 6 and 25 years), and 1,000 city dwellers, (700 adults and 300 children and youths). Segregated into four groups these 2,300 people showed the following results: of the city dwellers between 25 and 50 years of age 16.5 percent had healthy teeth, of those between the ages of 6 and 25 but 20 percent had sound teeth. The corresponding peasant groups of between 25 and 50 years showed 26 percent healthy teeth, and between 6 and 25 years 32 percent. The most interesting fact, however, is that among the city folk 25 to 30 percent cleaned their teeth regularly, while among the peasants only 1 to 2 percent cleaned their teeth. *Zoubolekarski Pregled.*

W. Linford Smith
Founder

ORAL HYGIEN

REA PROCTOR McGEE, D.D.S., M.D.,
Editor

Manuscripts and letters to the Editor should be addressed to him at 514 Hollywood Security Bldg., Los Angeles, California. All business correspondence and routine editorial correspondence should be addressed to the Publication Office of Oral Hygiene, Pittsburgh, Pennsylvania.

BOOK REVIEWS

New books are as important in scientific progress as fresh vegetables are in diet.

When we buy a book we wish to know what the book has to offer and how the offering is made.

A book that is well written, interestingly stated, illustrated, understandable, technically correct and well printed and bound appeals to us.

On the other hand we do not want "duds"—a "dud," as you probably know, is an unexploded enemy shell—it traveled the route but did not deliver the goods.

The best way to tell a good book from a poor one is to get it read by a recognized expert upon the subject of which the book treats.

This is also the best way to tell a "dud" if your reviewer has the nerve to tell the truth.

For a long time Oral Hygiene has felt the necessity of impartial and prompt book reviews. The editor cannot read them all and besides he is capable only of reviewing books upon the surgery of the face and mouth.

So a new and beautiful scheme has been evolved. The new books will be promptly and impartially reviewed by the heads of departments of the Dental School of the University of Southern California.

Books for review should be sent to the Editor.

Editorial Comment

C. EDMUND KELLS

[This ORAL HYGIENE is ready to go to press as we receive the news of Dr. Kells' death. The following editorial had been written in the hope that it might help to brighten his days of pain. One of his characteristic articles appears upon page 1071. Beginning on page 1096, we print the tributes of three of his friends.]

Three score years and nine in the progress of dentistry—equal to a thousand years in the human progress of the Middle Ages.

In that wonderful book by Eddie Kells he tells, as no one else has ever told, the story of your profession.

The son of a dentist he is himself the embodiment of those of whom he writes. If you have not read "Three Score Years and Nine," you have missed a bright spot in life. We cannot all come in personal contact with Eddie Kells, but we can enjoy his charm and friendliness, his candor, his experience, his learning, his neatness and his simplicity, through the printed page.

We are proud of our profession but there are many things we overlook in the rush of life.

Dentistry must have a great appeal to youth, otherwise there would be no freshmen.

Eddie Kells has crystallized that appeal. He has shown why he is yet a freshman. There must be something that can warm the cockles of the heart in dentistry, something besides hard work and bills.

Dr. Kells lets you in on what has interested him for three score years and nine. Success and failure, affluence and adversity, health and sickness, happiness and grief have all failed to dim his enthusiasm for this profession of ours. How can you resist reading it?

ONE HUNDRED YEARS AGO

Dr. H. L. Bennett sends a clipping, from the Providence, Rhode Island *Journal,* that appeared originally one hundred years ago. Originally the Providence *Journal* was known as the *Farmers and Manufacturers Journal.*

The oral hygiene article signed "F" was evidently written by a man who was a very well-informed dentist. It is very interesting to read the modern ideas expressed so long ago—the realization of the necessity for care of children's mouths—the systematic disturbances caused by mouth diseases—the evil result of malocclusion. Truly this ancient observer is more than up-to-date:

CARE OF THE TEETH

"The importance of attending to the Teeth of Children—It is owing too frequently to early neglect of parents, or guardians, that we witness so much irregularity in the formation of teeth, and so much suffering in those organs, among our rising population.

"During that period between shedding the first, and the growth of the second or permanent teeth, as much or more parental care is required than at any other period of a child's existence. To realize the truth of this assertion, we have only to look at the many distressing diseases of the body, whose origin can easily be traced to an unhealthy, decayed state of the teeth; and this curious condition is most frequently to be found in those individuals whose teeth are irregular, as there is great difficulty in brushing them and keeping them free from injurious collections.

"There is some excuse to be offered for many who neglect this duty we will admit; it is those who have been imposed upon by pretenders in the art of dentistry, and have met with injury from their hands; they become disgusted and irritated, and cry out against all who follow the profession; this is natural; but is it proper? Is it just? Let them do all that is necessary, let them make inquiries among their acquaintances, and particularly from their family physicians—in whom may confidence be placed, and the least that can be said, their cause of complaint will be very much diminished—and by this means quackery must be obliterated with all its attendant horrors.

"A child's first teeth, are but little more than half as large as the second, and there are but about two-thirds as many; now it stands to reason, that unless there is a very rapid growth of the jaws, the second set must be crowded and overlay each other; this necessary growth is not uncommonly the case, but far from always; and when otherwise, much art can be employed beneficially. I would here observe, that great injury has been done, even where the jaws have been favorable, by allowing the first set to remain too long, 'letting nature take its course'—by so do-

ing the fangs of the first teeth will give a wrong direction to the crowns of the second, and we witness too late the serious consequences of neglect. A remarkable case of this nature, presented itself to me a few weeks since, in a young man of this place, about twenty years of age; where all the upper teeth on the right side were displaced, with the exception of the three molars or grinders. The witnessing of this deformity has led me to offer these few remarks, in hopes that the subject may be more seriously considered than it has been by many heretofore. F."

A denture class

(Left to Right)

Top Row—Doctors C. S. Decker, Binghamton; J. A. Boarts, Pittsburgh; B. W. Garrison, Fort Worth; C. C. Patten, Boston; W. B. Dundon, Binghamton; G. A. Irwin, Terre Haute; H. I. Haines, Coatesville, Pa.; P. J. Valenzuela, Chile; C. L. Buckner, Knoxville.

Fourth Row—A. P. Dixon, Cumberland, Md.; T. Buchanan, Philadelphia; W. Hemley, Brooklyn; J. Neylon, Brooklyn; H. D. Weller, Indianapolis; R. J. Murray, Hartford; H. J. Kramer, Brooklyn; J. V. McAlpin, U.S.N., Washington, D. C.; W. F. McKinley, Wheeling.

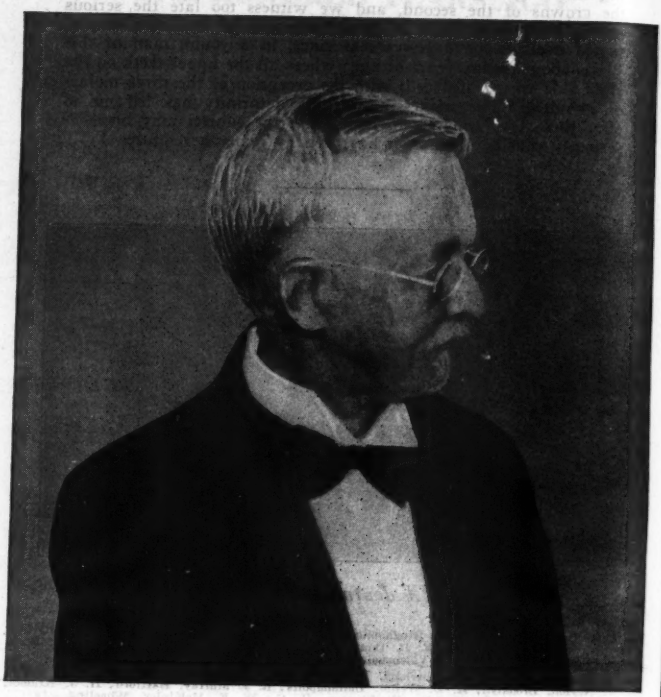
Third Row—T. B. Fowler, Morrisville, Pa.; I. Weinberger, Yonkers, N. Y.; C. F. Carr, Long Branch, N. J.; O. M. Dresen, Milwaukee; A. Strauss, Milwaukee; R. G. Gray, Syracuse; A. Gigoux, Chile; B. Smith, Philadelphia; H. C. Webb, Syracuse.

Second Row—D. A. Allen (patient); J. E. Walker, Evansville, Ind.; L. Rubin, Brownsville, Pa.; H. W. Catron, Knoxville; J. D. Reynolds, Marietta, Ga.; W. B. Byrnes, Pittsfield, Mass.; W. M. Burns, Brooklyn; S. S. Jaffe, Washington, D. C.; E. W. France, Syracuse.

First Row—J. S. Green, Syracuse; F. H. Eversull, H. D. Justi & Son; W. C. McClelland (Dr. Campbell's assistant); H. M. Justi, Jr.; Dayton Dunbar Campbell (instructor); A. P. Little, H. D. Justi; C. G. Lynch, Rochester; C. G. Lindberg, New York; J. A. Freedman, Steubenville, Ohio.

A service to the profession, designed to simplify the construction of full dentures and to make post-graduate work of this nature available in all sections of the country, has been inaugurated by H. D. Justi & Son of Philadelphia.

During the week of March 26th to 31st, 38 dentists from 14 states and one foreign country enrolled in the first class in full denture construction, held under the auspices of the Justi research bureau. The Bellevue-Stratford Hotel in Philadelphia was the scene of action.



C. Edmund Kells
1856-1928

C. Edmund Kells—Martyr to X-Ray

YOUR friend and my friend has crossed the frontier into that land of eternal youth.

That dear, delightful Eddie Kells, the embodiment of friendly enthusiasm—his quick brain happiest when with rapier-like thrust he drove home his argument. Ever in the advance-guard of science, alert in observation, keen in memory, practical in application, happy in sentiment—a truly wonderful personality.

Doctor Kells made the first x-ray picture of the teeth that the world ever saw. He was the pioneer of pioneers in dental x-rays. He paid the price of glory in multiple cancer of the hands and arms from x-ray burns. Twenty-seven amputations and more to come if he had lived.

He died a martyr to scientific advancement. Tulane University conferred a well earned L.L.D. upon him.

Dental literature has been enriched by his writings. Our readers throughout the world will miss his clever pen, his searching mind.

The editor will watch in vain for his familiar blue envelope in the mail from the South.

It hardly seems possible that Eddie Kells has left us. To all of us he bequeaths a memory of many happy, well filled days—a memory of courageous suffering without complaint—a memory of the highest type of professional man. May his excellence inspire us.

—Rea Proctor McGee.

My Friend, Eddie Kells

By Samuel Pepys, Jr., D.D.S.

A WIRE today from New Orleans informs me of the death of Dr. C. Edmund Kells. His death is to me a personal loss and it is a great loss to the dental profession.

There is probably no individual in the profession who enjoys as large a dental audience as Dr. Kells. Articles from his pen have been appearing almost monthly for years in the various dental journals.

He had always been an untiring worker for the cause of dentistry and was ever ready to assist anyone who sought his advice. In the May issue of ORAL HYGIENE there appears an article from his pen, "The Handwriting on the Wall," which shows the type of man he was.

I had known him intimately for twenty-five years and received my first x-ray interpretations from him. Little was known about the dangers of this agent when he started to investigate the value of the roentgen ray in connection with dentistry.

The procedure at that time was to take a photographer's plate, cut it into sections, wrap the cut-out plate with vulcanized rubber and then make the exposure—so different from the modern films used today and the safeguards incorporated in our up-to-date x-ray machines, for the prevention of x-ray burns.

The fact that Dr. Kells has paid the price of pioneering in x-ray work—which shortened his career—should be an object-lesson to those, who are using this method of diagnosing, to be cautious with the x-ray, although every method is now being employed to protect the operator as well as the patient.

Dr. Kells did much to advance dentistry in the city in which he practiced, having succeeded his father, who was for forty years one of the leading practitioners.

He was an individual of unusual initiative and was probably the first to recognize the value of an efficient office, having worked out a systematic record and cost system which is still modern. There are many men over the country whose success has been attributed to valuable advice received from Dr. Kells in the early days of practice.

All honor that could be bestowed upon a professional man had been bestowed in his case, with one exception, and that was that he was never President of the American Dental Association. He evaded this and many other offices.

Not long ago he wrote an article for ORAL HYGIENE on the selection of the President f the American Dental Association, calling attention to the fact that a man who is elected to this office is either ruined in health or loses his practice after serving his term, stating further that the office required that one have sufficient independent income to carry on the work.

Dr. Kells' writings were not confined to any specific subject. He was versatile in every phase of dentistry—scarcely a month passed but that some article from his pen showed that he was everlastingly on the job. Through his writings a good many reforms were brought about.

His sincerity was never questioned and at the time of his death he was writing a new work on "Operative Dentistry," which deals with the preparation of small cavities—now so readily recognized with the x-ray—cavities which have so frequently been overlooked.

I had the extreme pleasure of a visit with Dr. Kells many months ago and he informed me that this work was shortly to be presented to the profession. I trust that the manuscript is in such shape that it can be completed by our untiring worker, C. N. Johnson, who visited Dr. Kells only two weeks before his death and went over part of the manuscript with him.

The Chicago Odontographic Society, the New Orleans Dental Society and many other societies over the country have tendered him testimonial dinners and the New Orleans Society recently, in connection with Tulane University, established the Kells Memorial Library and Museum. Contributions to it have been sent from all over the world and the dentists of New Orleans are establishing one of the best libraries in the country through this memorial.

New Orleans, known as the Crescent City, is also known for its hospitality, and those of us who visit there never failed to see Eddie. Many a dinner I had in his home at Audubon Park and the belle of the South was ever ready to help make your stay a pleasant one.

The profession has lost one of its hardest workers —a martyr to dental research.

The Untimely Death of C. Edmund Kells

By Joseph A. Themper, D.D.S.,
Washington, D.C.

"The grass withers
The flower fades
But the deeds of the great
Stand forever."

DR. KELLS is dead. The giant who blinked a happy eye at every junior in the professional field, the "unconventional" and hypnotic humorist who decorated every gathering by his happy and enthusiastic self, lies still—without a murmur.

Not only did C. Edmund Kells contribute to what is of the best in the dental profession, but sponsored unequivocally much that was created by others. To immerse one's self in his two books, "The Dentist's Own Book" and "Three Score Years and Nine," is to find an endless treasure of the unbelievable accomplishment and unsurpassed vitality of ONE man during 48 years of a constant searching life. The minds of those who knew C. Edmund Kells personally have not yet returned to normal tranquility so as to be able to write an account of the vast and resourceful life of this dear teacher.

Some day, I hope, will find Dr. Kells' Boswell, who will unveil a fitting monument to this great pioneer in the profession. He gave to the profession his very best. There was no limit to his "pass it on."

He had undergone twenty-seven operations and amputations in recent years on his left arm, which had become infected through his experiments with the x-ray. His sight also had become impaired. But to the very last moment he carried the message to the rank and file of the profession.

He never raged against the laws of life—he tried to understand them and progress while changing them.

He took pride in his labor as well as in the labor of others. He deciphered the secret of his happiness by giving and sharing his experience with others.

The old practitioners have lost a dear comrade—the young a teacher, an adviser, who carried the torch of courage to the novice who needed a fatherly hand on the difficult path of dentistry. The few lines chosen for his last page of the book "Three Score Years and Nine," interpret him to us:

"Pass it on
Have you had a kindness shown?
Pass it on!
It was not intended for you alone
Pass it on!
Let it go traveling down the years
To wipe away another's tears
Until in heaven the deed appears.
Pass it on! Pass it on!"

Editor's Note

Dr. Kells' articles will continue to appear in ORAL HYGIENE for several months. Several of his famous "blue manuscripts" are on file—several others are in type. He wrote whenever the fancy seized him, keeping us supplied with material for many months ahead. Incidentally one of his last letters to the editor conveyed the request that we print a note to the effect that his reference to the late Dr. Edmund Noyes on page 672 of the April number should have carried a footnote explaining that the manuscript had been received by us prior to Dr. Noyes' death. Dr. Kells had forgotten the manuscript.

In printing it we intended to accompany it with an editorial note of explanation, but overlooked doing so.

Laffodontia

If you have a story that appeals to you as funny, send it in to the editor. He *may* print it—but he won't send it back.

A Scotchman was discovered wandering around Detroit with a pair of rumpled trousers over his arm. "Can I help you in any way?" asked a kindly citizen. "Man," replied the Scot, who was evidently a newcomer, "I'm looking for the Detroit Free Press."

A scrub-woman applied to a lady for work.

"What do you charge a day?" the lady asked.

"Well, mum," was the reply, "a dollar and a quarter a day if I eats myself, and a dollar if you eats me."

"Look here, Smith," said the boss, "you and Jones both started digging at the same time and he's now got a bigger pile of dirt than you have. How come?" "He's diggin' a bigger hole," said Smith.

"Is your husband much of a provider, Malindy?"

"He ain't nothing else, ma'am. He's gwine git some new furniture providin' he gits de money; he's gwine git de money providin' he goes to work; he's gwine to work providin' de job suits him. I never see sich a providin' man in all mah days."

Mistress (to applicant for position as maid)—"And why did you leave your last place?"

Applicant—"The mistress copied every new hat I bought."

"Rather a sharp thunder storm last night."

"I hadn't noticed; I was talking with my wife all evening."

Adam, after awakening from a deep sleep, and viewing for the first time his helpmate in all her marvelous beauty, smiled broadly in amazed admiration. Then he began counting his ribs. "I wonder," he mused, "if a man can do without all his ribs?"

"What are you doing there?" said a policeman to a man who was trying to remove a lamp from a bridge.

"My wife told me to bring home a bridge lamp, and I am trying to obey orders."

The sad looking man at the corner table had been waiting a very long time for his order. At last a waiter approached him and said:

"Your fish will be coming almost any minute now, sir."

"Oh, yes," said the sad man, looking interested. "And what bait are you using?"

Young Woman—"Whose little boy are you?"

Sophisticated Willie—"Be yourself! Whose sweet mamma are you?"

It isn't the first cost of short skirts that bothers the fair wearer—it's the upcreep.

"These girls! Doggone 'em, they forget my kisses and I forget their names."

Manager: "What do you mean by arguing with that lady? Let her have her own way. Remember, a customer is always right."

Assistant: "Why, boss, she said we were swindlers."